DISTRICT OF COLUMBIA
DOH Office of Adjudication and Hearings
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DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, V. SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC. AND YVONNE MOHAMMED, Respondents	Case Nos.: I-00-40082 I-00-40083 I-00-40152 I-00-40153

FINAL ORDER

I. Introduction

On April 18, 2000, the Government served two Notices of Infraction (Nos. 00-40082 and 00-40083) upon Respondents Symbral Foundation for Community Services, Inc. ("Symbral") and Yvonne Mohammed. Both Notices of Infraction alleged that Respondents violated 22 DCMR 3520.3, which describes certain professional services that an operator of a group home for mentally retarded persons must provide to the residents. Notice of Infraction No. 00-40082 alleged that Respondents had committed a violation at a group home at 7416 Blair Road, N.W. (the "Blair Road Facility"), while Notice of Infraction No. 00-40083 alleged that a violation occurred at a group home at 7533 12th Street N.W. (the "12th Street Facility"). Both notices alleged that the violations had been determined on March 9, 2000, and sought a fine of $500 for each violation.

Respondents did not file answers to the Notices of Infraction within the required twenty days after service (fifteen days plus five additional days for service by mail pursuant to D.C. Official Code § 2-1802.05). Accordingly, on May 18, 2000, this administrative court issued separate orders finding Respondents in default in each case and assessing separate statutory penalties of $500 in each case, as required by D.C. Official Code § 2-1801.04. The orders also required the Government to serve second Notices of Infraction in each case, as required by D.C. Official Code § 2-1802.02(f).

The Government served the second Notices of Infraction on July 11, 2000. On July 25, 2000, Respondents filed pleas of Deny to both charges. The cases were consolidated and an evidentiary hearing was held on November 17 and November 30, 2000. Carmen Johnson, Esq. and Carolyn Sims, Esq. represented the Government; Respondent Yvonne Mohammed represented both Symbral and herself. At the hearing, the Government moved to amend the Notices of Infraction by replacing the two charges of violating 22 DCMR 3520.3 with two allegations that Respondents violated 22 DCMR 3520.13, which requires a group home to "show evidence" that it has made arrangements for professional services needed by a resident. Respondents did not object, and I granted the motion.

The parties submitted post-trial briefs, and the record closed on February 20, 2001. Along with its post-trial brief, Respondents filed a motion to re-open the record to admit Respondents' Exhibits ("RX") 224 and 230. Respondents stated that they were not certain whether those documents had been offered into evidence, although they were identified and discussed by witnesses. The Government has not opposed Respondents' motion. Exhibit 230 is

in evidence, but no one offered RX 224 at the hearing. Respondents' unopposed motion, therefore, is granted in part and denied in part as moot. RX 224 is admitted into evidence.

Based upon the testimony of all the witnesses, my evaluation of their credibility, the documents introduced into evidence and the entire record in this matter, I now make the following findings of fact and conclusions of law.

II. Findings of Fact

A. The 12th Street Facility

The 12th Street Facility is a group home for mentally retarded adults operated by Symbral. Respondent Yvonne Mohammed is the Chief Executive Officer of Symbral. On March 6, 2000, Marcella Torbit, an inspector employed by the Department of Health, visited the 12th Street Facility in response to a complaint from a private monitoring group concerning the dental care received by one of the residents there (referred to in this opinion as "Client # 1"). Upon her arrival, Ms. Torbit observed that Client # 1's gums were visibly overgrown, partially obscuring his teeth, a condition known as "hyperplasia." Hyperplasia is a known side effect of long-term use of Dilantin, an anti-seizure medication that Client # 1 had been taking. On July 20, 1999, the dentist to whom Symbral had taken Client # 1 for evaluation recommended surgery, known as a gingivectomy, to remove the overgrown gum tissue. On the day of the inspector's visit, more than seven months later, the surgery had not taken place, and the overgrowth of the gum tissue was more severe.

During 1999, Symbral became dissatisfied with the dentist to whom it had sent the residents of its group homes, believing that the dentist was prescribing unnecessary procedures.

At some point after July 20, 1999, Symbral began searching for a new dentist who would accept Medicaid reimbursement and would treat its residents. Symbral located a new dentist in February 2000. Symbral's witness, Mr. LaRose, testified generally that Client # 1's gingivectomy was delayed by both the search for a new dentist and the need for the dentist to obtain pre-authorization from Medicaid before the procedure could occur. He offered no details, however, on when Symbral decided to change dentists, how long the search took, and what follow-up Symbral initiated to make sure that any dentists' requests for pre-authorization were being processed.

B. The Blair Road Facility

The Blair Road Facility also is a group home for mentally retarded adults operated by Symbral. The Government alleges that Respondents did not provide proper medical care to one of the residents of that facility. The resident will be referred to as Client # 2.[1] Client # 2 was profoundly mentally retarded and suffered from cerebral palsy, seizure disorder, chronic edema and cervical stenosis.[2] He was non-ambulatory and non-verbal.

In its post-trial brief, the Government identifies three specific periods during which it charges that Respondents failed to provide adequate medical care for Client # 2. The findings of fact concerning each period are set forth below.

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[1] At the hearing, the witnesses usually referred to this resident as Client # 1 at the Blair Road Facility. In the interest of clarity, and specifically to avoid confusion with Client # 1 at the 12th Street Facility, I will follow the practice of the parties in their post-trial briefs and refer to the resident of the Blair Road Facility as "Client # 2."

[2] Client # 2 died after the events at issue in this case. There are no allegations in this case that Respondents committed any violations that led to his death.

1. October 28, 1999 to November 15, 1999

Due to both his lack of mobility and his extremely thin condition, Client # 2 was susceptible to the development of decubitus ulcers, also known as bed sores or pressure sores. He previously had developed pressure sores that were severe enough to require surgery. All parties agree that the standard nursing treatment to prevent the development of pressure sores (and to care for them if they actually develop) includes frequent turning and repositioning of the patient to relieve pressure against the skin. The parties also agree that the standard nursing treatment for a pressure sore includes placing a dressing over it.

On October 28, 1999, Client # 2 had developed a pressure sore. There is no documentation in the facility's records that he received any treatment for that sore between October 28 and November 15. Indeed, there is no entry in the facility's nursing records between those two dates and, therefore, no documentary evidence that he received the standard nursing treatment described above. Petitioner's Exhibit ("PX") 106. Symbral's nursing director conceded that the nursing staff did not make proper notes during this period. (11/30/00 Transcript at 78.)

2. December 12, 1999 to December 17, 1999

On December 1, 1999, Client # 2 entered Georgetown University Hospital for surgery to cure the pressure sore first recorded on October 28. He remained in the hospital until December 8, 1999, when he was discharged to the Blair Road Facility. On December 17, 1999, he exhibited shortness of breath and was taken to the emergency room at Providence Hospital. He was admitted there with a diagnosis of adynamic ileus, dehydration and possible sepsis. While

in the hospital, his right leg was amputated due to gangrene. The parties dispute whether the gangrene had begun to develop between December 12 and December 17 while he was at the group home and, if so, whether Symbral responded properly to it.

The Government contends that hospital records show that gangrene was present on Client # 2's right foot when he was admitted to Providence Hospital on December 17. The only record evidence supporting that contention is RX 224, a Providence Hospital report entitled "History and Physical Report," signed by the attending physician on January 5, 2000. The report contains various entries describing Client # 2's medical history, the history of his present illness, and laboratory data. The Government relies upon the entry entitled "Physical Examination," which reads as follows:

> Pulse 60. Temperature 96.8. Blood Pressure 118/70. Respiration 20. The patient is lying in bed, alert and awake, with mild increasing respiratory rate. Head, eyes, ears, nose and throat: Non-traumatic. Pupils equal, round, reactive to light and accommodation. Neck: Supple. No jugular venous distention. Lung fields _____ [*sic*] sounds but no wheezing. Heart: S1, S2. Regular rhythm. Abdomen: Soft, non-tender. Bowel sounds present. Extremities: Contracted, both upper and lower, lower more than upper. *Also there is a small, dry blackish area on the right foot, possibly emerging gangrenous changes.* Rectal was guaiac negative.

RX 224 at 1 (emphasis added).

A later section of the same report states "The patient also showed progressive increasing gangrenous area on his foot. In view of that, a surgical consult was sought, who recommended above knee amputation of the right limb . . . ." *Id.* at 2. The Government's theory is that the "Physical Examination" portion of the report reflects information obtained upon Client # 2's December 17 admission to the hospital and that Respondents should have noticed and arranged

for medical attention for the "small dry blackish area" on his right foot at some time before December 17. According to the Government, Respondents' failure to do so led to the development of gangrene and the eventual amputation of Client # 2's leg.

Respondents counter that the gangrene developed after Client # 2's admission to the hospital and that there were no blackened areas on his foot before his admission. In addition to the testimony of staff members who stated that they saw no blackened areas or other evidence of gangrene before Client # 2 went to the hospital, Respondents rely upon two other Providence Hospital records. The first is RX 230, which consists of handwritten notes made by the emergency room personnel on December 17 when Client # 2 first arrived. Those notes observe that the Client # 2 had "3+ edema to feet bilaterally." RX 230 at 1. Ms. Sklencar, the Government's expert witness on nursing care, conceded on cross-examination that the emergency room nurse would have seen any developing gangrene in the course of observing the edema in his feet. (11/17/00 Transcript at 199-200.) The emergency room notes, however, contain no observation of gangrene or dark spots on his foot. Respondents also point to RX 223, a Providence Hospital report of a neurosurgical consultation that took place on December 23, 1999, six days after Client # 2's admission. The attending physician sought the consultation to evaluate whether surgery would be helpful in treating Client # 2's spinal stenosis. The neurosurgeon reported that the Client # 2 "withdraws all extremities to pin prick." RX 223 at 1. The report does not mention gangrene or black spots on the right foot, even though the neurosurgeon would have observed that foot during the pin prick test.

I find that the Government has failed to prove by a preponderance of the evidence that Client # 2 had developed gangrene or black spots on his foot before his admission to Providence

Hospital on December 17, 1999. The notes from the emergency room, RX 230, are the most persuasive evidence on this point. It is unlikely that there were any blackened areas on Client # 2's foot that went unnoticed by the emergency room staff when they observed the edema on his feet. Moreover, RX 224, the Government's only support for its position, does not state the date of the physical examination reported therein. Because the "Physical Examination" section of the report notes "possibly emerging gangrenous changes," *id.* at 1, while the body of the report describes a "progressive increasing gangrenous area on [Client # 2's] foot," *id.* at 2, the physical examination most likely occurred some time before January 5, the date of the report. There is no evidence, however, that the examination occurred upon admission. Indeed, RX 224 describes Client # 2's abdomen as "[s]oft, non-tender" during the physical examination, *id*. at 1, while the emergency room notes initially describe it as "distended and rigid," and later in the day describe it only as "less rigid." RX 230 at 1. This further indicates that the physical examination described in RX 224 most likely did not occur when Client # 2 first came to the hospital. I find, therefore, that the "small, dry blackish area on the right foot" mentioned in RX 224 was not present when Client # 2 came to Providence Hospital on December 17.

3. March 6, 2000 to March 9, 2000

Ms. Torbit and another investigator visited the Blair Road Facility on March 6, 2000 to investigate reports that Client # 2 was not receiving proper medical care. They returned to the facility on March 9 to conduct a follow-up investigation. At that time, they noticed a small blackened area on one of Client # 2's toes, which had not been present during their visit three days earlier. The inspectors pointed out the blackened area to the staff members on duty, who had not noticed it previously. The inspectors insisted that Client # 2 be taken to the emergency

room immediately to determine if he was developing gangrene in his left foot as well. The facility staff brought him to the emergency room, where a doctor confirmed that he did not have gangrene. RX 203.

III. Conclusions of Law

A. Elements of the Offense

The Government alleges that Respondents violated 22 DCMR 3520.13, which provides:

> If a resident evidences the need for a professional service for which arrangements do not exist, the [group home] shall have fourteen (14) days to show evidence of arrangements for provision of the professional service, except that in life threatening situations, arrangements must be made immediately.

There are three elements to a violation of § 3520.13:

1. A group home resident must show a need for a professional service.[3] This is an objective standard, *i.e.,* the preponderance of the evidence must show that a qualified professional reasonably would conclude that a specific service is necessary.

2. The resident must not be receiving the needed service.

3. The group home must "show evidence" that arrangements have been made for the needed service within the time limits mandated by the regulation, *i.e.* within 14 days

[3] The services of physicians, dentists and nurses are included within the "professional services" covered by the regulation. 22 DCMR 3520.2(a), (b), (e).

of manifestation of the need for services, except in life-threatening situations. This element requires a facility both to make arrangements for the services and to provide adequate evidence that it has done so.

The evidence concerning each facility at issue will be evaluated according to these standards.

B. The 12th Street Facility

It is undisputed on this record that, by July 20, 1999 at the latest, Client # 1 evidenced a need for a gingivectomy. Nor is there any dispute that he had not received the gingivectomy by March 6, 2000, more than seven months after Symbral's dentist had recommended it. Symbral defends its failure to meet the 14-day deadline in §3520.13 on two grounds: that it was seeking another dentist and that it did not receive Medicaid pre-authorization for the procedure. Neither defense is sufficient in the circumstances of this case.

Regardless of the validity of Symbral's concern that its former dentist was recommending some unnecessary procedures, Symbral has not disputed that Client # 1 needed the gingivectomy. Indeed, the overgrowth of his gums was apparent simply by looking at him. A facility's unilateral doubts about the care provided by a particular professional are not an excuse for failing to arrange professional services required by §3520.13. If a group home resident needs a professional service, §3520.13 requires a facility to arrange for that service within 14 days (unless it must act sooner because the situation is life-threatening). Of course, a facility that is uncertain about whether a resident actually needs a recommended service is free to seek a second

opinion, and may be well advised to do so in some circumstances.[4] Section 3520.13, however, does not authorize an indefinite delay in providing services that the facility admits are necessary. Once the need for the gingivectomy was evident, Symbral had 14 days to make reasonable arrangements for it to be performed.

Respondents' assertion that the failure to receive pre-authorization from Medicaid prevented them from arranging for the gingivectomy also is insufficient on this record. To be sure, a facility can establish an affirmative defense to a charge if it diligently does everything reasonably possible to comply with a regulation, but is unable to do so because a government agency fails to take required action. *See DOH v. Multi-Therapeutic Services, Inc.,* OAH No. I-00-40121 at 10-11 (Final Order, November 29, 2001). Here, however, the vague testimony of Symbral's witness that there were delays in obtaining pre-authorization from Medicaid does not sufficiently show that circumstances beyond Symbral's control were the exclusive cause of the delay in arranging the necessary services. The record does not show when pre-authorization requests were submitted or what steps Symbral took to monitor the dentists' efforts to submit the necessary information to Medicaid. Absent such evidence, there is no basis for concluding that

[4] Referring a group home resident to a medical or dental professional whom the facility believes is providing incompetent, inadequate or unnecessary care may violate the facility's obligation under federal law to provide for medical and dental care, 42 CFR § 483.460(a)(3), (g)(2), and its obligation under D.C. Official Code § 7-1305.05(g) to furnish "prompt and adequate medical attention for any physical ailment." Any non-compliance with these provisions could subject a facility to loss of its license, loss of Medicaid funding or fines pursuant to 22 DCMR 3523.1. The facility also might face liability for negligence. *See Chadbourne v. Kappaz,* 779 A.2d 293, 295-97 (D.C. 2001) *and Thoma v. Kettler Bros., Inc.,* 632 A.2d 725, 727-30 (D.C. 1993) (Defendant's violation of a statute or regulation may be negligence *per se* or may be evidence that a duty of care exists and has been breached.) *See also District of Columbia v. Wilson,* 721 A.2d 591, 597 (D.C. 1998) *and Phillips v. District of Columbia,* 714 A.2d 768, 772-73 (D.C. 1998) (Liability for improper medical care when the defendant is responsible for the plaintiff's care and safekeeping).

Symbral did everything reasonably possible to make the necessary arrangements for Client # 1's treatment. Consequently, I conclude on this record that Symbral violated § 3520.13 by failing to make arrangements for necessary dental services for Client # 1 within 14 days of July 20, 1999.

C. The Blair Road Facility

1. October 28 to November 15, 1999

Respondents do not dispute the Government's contention that Client # 2 required a dressing on the pressure sore, as well as regular turning and re-positioning to treat the sore and to reduce the likelihood that he would develop additional pressure sores. Nor do they dispute the Government's contention that the facility's records for the period October 28 to November 15 (a period greater than 14 days) contain no entries documenting that Client # 2 received those necessary services. Symbral insists, however, that its employees applied dressings and regularly turned and re-positioned Client # 2 during this period, although its witness admitted that the nurses did not properly document their treatment efforts.

As noted above, §3520.13 requires both that a group home arrange for needed professional services and that it provide evidence that it has done so. This case illustrates why such evidence must be provided. The parties agree that placing a dressing on the sore and regular turning and re-positioning were necessary features of the nursing care that Client # 2 should have received. The Government's inspectors, however, can not be present to monitor a group home's operations at all times. Unless a facility provides some form of contemporaneous or nearly contemporaneous evidence sufficient to show that the facility is meeting its obligations to provide the professional services required by § 3520.13, it will be difficult, if not impossible,

for the inspectors to determine whether the facility has furnished those services.[5] Because of the importance of the professional services governed by 22 DCMR 3520 to the health and safety of the residents, it is especially important that inspectors be able to tell whether those services have been received. By failing to document that Client # 2 received the nursing services that he required from October 28 to November 15, therefore, Symbral did not comply with its obligation under § 3520.13 to "show evidence of arrangements" for such services.

2. December 12, 1999 to December 17, 1999

The Government's theory for this period is that Symbral failed to provide necessary professional services to Client # 2 because it took no action in response to the blackening of his right foot. The Government, however, did not prove that there was any blackening of the foot before Client # 2's hospitalization on December 17. Client # 2, therefore, failed to show any need for a professional service for his right foot during the December 12-17 period. Accordingly, the Government did not prove one of the necessary elements of a § 3520.13 violation for that period.

3. March 6, 2000 to March 9, 2000

The Government's theory for this period is that a blackened area developed on Client # 2's left foot some time between March 6 and March 9, 2000, and that Symbral did not provide a necessary professional service in response. The Government, however, did not prove what

[5] Because Symbral provided no contemporaneous or nearly contemporaneous evidence of the arrangements it made for Client # 2's treatment, I need not decide the precise form that such evidence must take, including whether oral notice to appropriate persons at the Department of Health would satisfy a facility's obligation to "show evidence."

professional service was necessary.[6] The facility's staff members took Client # 2 to the emergency room at the inspectors' insistence. There was no expert testimony that anything else should have been done. Because the Government did not prove what professional service was necessary between March 6 and March 9, it did not prove a violation of § 3520.13 during that period.

D. Liability of Ms. Mohammed

The evidence establishes that Ms. Mohammed is Symbral's Chief Executive Officer, but there was no evidence that she had any involvement in Symbral's failure to arrange for the gingivectomy for Client # 1 or in its failure to provide evidence that it had arranged for the necessary nursing services for Client # 2. Accordingly, while Symbral is liable for the violations of § 3520.13 discussed above, there is no basis for finding Ms. Mohammed personally liable for those violations. *DOH v. D.C. Family Services, Inc.*, OAH No. I-00-40138 at 6-7 (Final Order, October 22, 2001). The charges against her, therefore, will be dismissed.

E. Fines and Penalties

Violations of § 3520.13 are punishable by a fine of $500. 16 DCMR 3239.2(e). For its two violations, therefore, Symbral must pay $1,000 in fines. In addition, the Civil Infractions

[6] It seems reasonable that a patient who contracts gangrene in one foot should be monitored for signs of possible gangrene in his other foot. But how and when to monitor is not commonly known by persons outside the health care professions. Expert testimony, therefore, is necessary to establish the frequency of such monitoring, the symptoms that the monitor should look for, and the proper actions to be taken if symptoms are found. *See DOH v. D.C. Family Services,* OAH No. I-00-40138 at 10-12 (Final Order, October 22, 2001) (Expert testimony necessary to establish medical matters not within common knowledge.)

Act, D.C. Official Code § 2-1802.03, requires the recipient of a Notice of Infraction to demonstrate "good cause" for failing to answer it on time. If a party can not make such a showing, the statute requires that a penalty equal to the amount of the proposed fine must be imposed. D.C. Official Code §§ 2-1801.04(a)(2)(A) and 2-1802.02(f). Respondents introduced no evidence of the reasons for their failure to answer the first Notices of Infraction. Accordingly, there is no basis for a finding that they had good cause for failing to answer and the statutory penalty of $500 must be imposed for each Notice of Infraction, a total penalty of $1,000. Because the "statutory penalty for failure to file does not depend upon whether the Government has established the underlying violations," *DOH v. Washington General Contractors,* OAH No. I-00-10387 at 11 (Final Order, July 11, 2001), Ms. Mohammed is liable for the statutory penalty even though she is not liable for the violations alleged in the Notices of Infraction.

IV. Order

Based upon the foregoing findings of fact and conclusions of law, it is, this _____ day of _____, 2002:

ORDERED, that Respondent Symbral Foundation for Community Services, Inc. shall pay a total of **TWO THOUSAND DOLLARS ($2,000)** in accordance with the attached instructions within twenty (20) calendar days of the date of service of this Order (15 days plus 5 days service time pursuant to D.C. Official Code §§ 2-1802.04 and 2-1802.05); and it is further

ORDERED, that Respondent Yvonne Mohammed is **NOT LIABLE** for violating 22 DCMR 3520.13, as alleged in the Notices of Infraction, as amended. Ms. Mohammed, however, is jointly and severally liable with Symbral for a penalty of **ONE THOUSAND DOLLARS**

($1,000) for failing to file timely answers to the Notices of Infraction. If Symbral fails to make the payment ordered in the preceding paragraph, Ms. Mohammed will be liable for payment of the $1,000 penalty; and it is further

ORDERED, that if the Respondents fail to pay the required amounts in full within twenty (20) calendar days of the date of mailing of this Order, interest shall accrue on the unpaid amount at the rate of 1 ½% per month or portion thereof, starting from the date of this Order, pursuant to D.C. Official Code § 2-1802.03 (i)(1); and it is further

ORDERED, that failure to comply with the attached payment instructions and to remit a payment within the time specified will authorize the imposition of additional sanctions, including the suspension of Respondents' licenses or permits pursuant to D.C. Official Code § 2-1802.03(f), the placement of a lien on real and personal property owned by Respondents pursuant to D.C. Official Code 2-1802.03 (i), and the sealing of Respondents' business premises or work sites pursuant to D.C. Official Code § 2-1801.03 (b)(7).

/s/ 1/14/02

John P. Dean
Administrative Judge